STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445071	A. BUILDING _____ B. WING _____	C 01/22/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE COUNTY NURSING HOME	1850 OLD KNOXVILLE ROAD TAZEWELL, TN 37879

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226 SS=D	483.13(c) STAFF TREATMENT OF RESIDENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Intakes: TN00024597 Based on medical record review, policy review, and interview, the facility failed to implement policy for investigating and report unknow injury. The findings included: Resident #1 was admitted to the facility on February 9, 2000, with diagnoses including Dementia, Diabetes, Psychosis, and Hypertension. Medical record review of the Minimum Data Set dated November 11, 2009, revealed the resident had short and long term memory problems, had moderately impaired decision making skills, was extensive assist for transfers, and was non ambulatory, had physically abusive behaviors and was resist to care. Review of the facility's policy Abuse revealed ...II. B. The charge nurse is to go directly to the affected resident to assess: 1. Physical status: a. Bruises and welts ...2. Investigation, reporting and response. 1. The facility will conduct and investigation of an alleged abuse/neglect ... Interview with the DON (Director of Nursing) on January 21, 2010, at 10:10 a.m., in the DON's	F 226	**F226** Resident # 1 cited in the deficient practice was assessed by the nursing staff on 11 p.m. to 7 a.m. shift at the time of observation of injury. This event was reported to the following shift (7 a.m. to 3 p.m.) informing the nurse receiving report that the Resident had a 3 cm X 1 cm bruise on left side of forehead. The 11 p.m. to 7 a.m. nurse assessed the Resident but failed to complete an occurrence report, notify physician and family, as well as chart the finding in the Resident record as per facility policy. After the Director of Nursing became aware of the occurrence, the physician was notified and an order for radiological study was received and completed. Results of the study were negative. A thorough investigation of the occurrence was immediately initiated. An attempt was made by the Director of Nursing to notify Resident's next of kin by telephone but a message had to be left requesting the nephew to call the facility. The nephew was notified of the occurrence on 12/01/09 by the Director of Nursing. Electronic self report to the State	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Tim S Brown — TITLE: Administrator — (X6) DATE: 2/5/10

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 226	Continued From page 1 office, revealed the resident had a discoloration (bruise) on the forehead on November 23, 2009, of unknown etiology. Continued interview with the DON revealed the nurse on 11-7 shift gave verbal report to the 7-3 shift nurse the resident had bruise on forehead. Further interview with the DON confirmed the nurse did not document the bruise or notify the DON. The DON confirmed the staff reported the bruise on November 30, 2009 (7 days), at which time the investigation was initiated. Interview with the DON on January 21, 2010, at 10:10 a.m., in the DON's office, confirmed the facility failed to implement policy and follow procedures.	F 226		
F 281 SS=D	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Intakes: TN00024597 Based on medical record review and interview the facility failed to follow physician's orders for one resident (#1) of five resident's reviewed. The findings included: Resident #1 was admitted to the facility on February 9, 2000, with diagnoses including Dementia, Diabetes, Psychosis, and Hypertension. Medical record review of the Minimum Data Set dated November 11, 2009, revealed the resident had short and long term memory problems, had moderately impaired	F 281	**F 281** Resident #1 cited in the deficient practice was assessed by the MDS Coordinator and found on 11/30/09 that Resident didn't have the ordered padded side rail applied. Investigation identified that padding was removed for laundering and staff failed to reapply. Padding for side rails was reapplied. Responsible person: MDS Coordinator. Completion Date 11/30/2009 Mandatory staff education for Nursing Home housekeeping department will be conducted stressing the importance of replacing side rail padding immediately after cleaning or if padding must leave room then to replace with another set of pads.	11/30/09

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F 281	Continued From page 2 decision making skills, was extensive assist for transfers, and was non ambulatory, had physically abusive behaviors and was resist to care. Medical record review of the physician's orders dated October 2009, revealed the resident was to have padded side rails. Interview with the Director of Nursing (DON) on Janaury 21, 2010, at 10:10 a.m., in the DON's office, revealed the resident had a discoloration on the forehead on November 23, 2009, of unknown etilogy. Continued interview with the DON verified the resident was resist to care and periods of combative behaviors. Further interview with the DON on January 21, 2010, at 10:10 a.m., confirmed at the time of the discoloration on the resident's forehead, the padded side rails were not in place.	F 281	Responsible person: Housekeeping Supervisor. Completion Date 02/11/2010 The MDS Coordinator will review 100% of Resident charts to ensure that the C.N.A. worksheets and care plans are current and complete. 100% of Resident rooms have been audited by Ward Clerks to ensure that all patient care/safety items are in appropriate use as listed on the worksheets and care plans. Responsible person: Director of Nursing. Completion Date 02/05/2010 Weekly monitoring will be performed by Ward Clerks February – April 2010 to ensure that 100% of Residents have 100% of patient safety/care items in use as listed on worksheets and care plans. A log will be completed after each audit by the assigned Ward Clerk. Results will be aggregated and reported to the Director of Nursing weekly and the Nursing Home Administrator, Medical Director, and Quality Management Committee monthly three times. Responsible person: Director of Nursing. Completion Date 2/5/10	2/11/10 2/05/10 2/05/10